InterRAI Coding
Quick Guide

Section A:

- A12 “Residential/Living Status” and A13a “Marital/Living Status” should align with each other and with the participant case summary screen.
- A12 coding - RCFs should be coded as 2 (board and care) and ALFs should be coded as 3 (assisted living or semi-independent living). “Other” is not an appropriate coding for someone residing in a RCF or ALF.
- A13 coding - RCFs and ALFs should be coded as 13 (RCF). “Other” is not an appropriate coding for someone residing in a RCF or ALF.

Section B:

- B4 “Residential History Over Last 5 Years” must be updated at each assessment as this question plays a key part for vulnerable populations in the new algorithm. Anyone currently living in a one of these settings should be scored as “Yes” for this question. Really keep this question in mind as you go to facilities for assessments.

Section C:

- C1 “Cognitive Skills for Daily Decisions Making” is the most important question in this section for the algorithm. We must make sure this one is coded appropriately or individuals may not receive the points they may be eligible for. C1 combined with C2 “Memory Recall” and C3 “Periodic Disordered Thinking/Awareness” allows for additional pointing. Please be sure to ask yourself if someone scored in one area, should they be scored in another. It is likely someone with difficulty making daily decisions will also have procedural or situational memory issues and vice versa.

Section D:

- D1 “Making Self Understood” and D2 “Ability to Understand Others” should be closely evaluated for individuals with dementia and developmental delays. Again these questions may go hand in hand with Section C and combined should paint a consistent picture.
- Significant vision impairments are captured in the algorithm under D4 “Vision”. If an individual is blind or near blind, please remember to code this question appropriately.

Section E:

- E3 “Behavior Symptoms” should be closely considered for individuals with a developmental delay, Dementia, and MI diagnosis. Also remember other diseases such as Parkinson’s may have these symptoms too.
- Ask yourself have they ever had these symptoms and if it weren’t for their current intervention (HCBS, DMH, medications, etc.) would they exhibit them. If the answer is yes, at a minimum “present but not exhibited in the last 3 days” should be coded.

Section G1:

- This section looks at the amount of the task the participant is able to complete on their own. Pay particularly close attention to meal prep and medication management as are standalone categories based solely on these questions.
- When coding assistance needed with stairs, determine how much assistance is needed to safely climb a full flight of stairs. Reminder G1 does not look at weight-bearing support, just whether assistance is needed throughout the task. This can be as simple as holding onto an arm to prevent falls or to help carry assistive devices or oxygen. It is okay for stairs and walking/locomotion to not align as stairs is an earlier loss activity.
- When coding assistance needed with Meal Preparation ask yourself how much assistance is needed to complete the task safely. This is particularly important with the frail elder population. While their "performance" may be independent, through observation you see their gait is unsteady, they are weak and unable to stand for long periods, etc. In this scenario their "capacity" would be scored lower based on your observations. Also keep in mind those with a cognitive deficit and determine if there are safety concerns such as forgetting to turn off the stove.
- Please see medication management guidance for thorough review of this question.

Section G2:

- This section looks at the amount of weight bearing assistance needed to complete the task. Therefore we should look at the whole task and code based on the portion of the task where the most help is needed.
  - Ex: The individual may be able to bathe sitting on their shower chair independently however they are unable to step into the bath independently, therefore the transfer into the bath is where the most assistance is needed and the coding should be based on how much help they need during that small piece of the task where the most help was needed.
- G2e "walking" looks only at how an individual walks between locations on the same floor. G2f "locomotion' looks at how an individual walks and/or wheels between locations on the same floor.
  - **If an individual only walks** – walking and locomotion scores will be identical and based on the individual's ability to walk between locations on the same floor.
  - **If an individual only wheels** – walking will be an 8 and locomotion will be based on the individual's self-sufficiency once in the chair.
  - **If an individual walks AND wheels** – walking will be based on the individual's ability to walk between locations on the same floor. Locomotion will be based on the 3 most dependent episodes of walking and wheeling over the last 3 days. Most often, walking will be the most dependent episodes of locomotion, and the locomotion score will therefore match the walking score. However, someone with arm weakness might need limited assistance with walking, but total dependence while wheeling. In this case, locomotion would be scored higher than walking.
- Incontinence points are captured in G2h "Toilet Use". If someone is identified in Section H as having incontinence ask yourself if they need assistance cleaning up the incontinent episode. If so, G2h should reflect that need.
- These questions should paint a consistent picture with section J1 – 3.

Section H:

- Incontinence should be scored no matter the type or cause.
- If anyone has an ostomy or catheter, this should be indicated here in order for the individual to receive points in treatments. Catheter/ostomy leaks or spills should not be considered when coding H1 and H3. If a participant has a catheter or ostomy, H1 and/or H3 should be coded as a 1, regardless of leaks or spills.

Section I:

- Each individual should be coded as having at least one primary diagnosis.
- Every diagnosis does not have to be listed if the list is long. Just be sure to include those that impact the need for services the most.

Section J:

- J1 "Falls" and J2 (if applicable) should be updated at every assessment. If a participant mentions a recent fall it is important these questions are updated accordingly to ensure safety risks are accurately scored.
- J3 "Balance Frequency" should also be updated at each assessment to capture safety concerns associated with balance and gait. If an individual is unable to walk coding should reflect the following:
    - J3a – Difficult or unable to move to a standing position unassisted
        - Code as 4 – exhibited daily in the last 4 days
    - J3b – Difficult or unable to turn self around and face the opposite direction when standing
        - Code as 4 – exhibited daily in the last 4 days
    - J3d – Unsteady gait
        - Code as 0 – not present
- J3 "Psychiatric" should be coded much like the behaviors in section E. Remember to ask yourself if the individual has ever exhibited the behaviors, if so determine if they would return if it weren't for services or medications that they are receiving. If the answer is yes, at a minimum "present but not exhibited in the last 3 days" should be coded.

Section K:

- K2e (physician ordered diet) should only be scored when a specific diet has been ordered and involves weighing, measuring, calculating, and/or restricting selected nutrient components such as calories, sodium, sugar, etc. A doctor recommending someone "watch their sugar" does not count as the restricting is not specifically counted, weighed, or measured.

- K3 (mode of nutritional intake) should be scored for individuals requiring modified ways to receive their nutritional needs. This section can really paint a picture for care plan needs such as increased time under dietary to cut up/puree meals. It is especially important to capture those with tube or TPN feedings in this section as it impacts treatment points.

Section L:

- L1 (most severe pressure ulcer) should be scored based on the most severe ulcer regardless of type of ulcer.
- If the participant has a skin defect it must be captured in L1-L5. If a participant has an ulcer or skin issue, ask yourself if Section N wound care should also be marked.

Section N:

- N2 (Treatments) should be coded for any treatments the individual is **currently** ordered to receive. If a treatment is ongoing but has not been done within the last three days such as chemotherapy, code as 1 – ordered but not yet implemented
- N3 (Formal Care) should only include services outside of DSDS services. This section is to be used to help determine if any needs are met elsewhere during care planning.
- N7 (Monitoring) is only coded if an individual has ongoing (at least monthly) monitoring for the **same** condition by a physician or licensed mental health professional. For example someone on dialysis will usually have frequent laboratory monitoring. Monitoring would not count for someone who sees a doctor monthly due to having varying specialists for various conditions. For example one month they see their primary, next month the cardiologist, the next the dermatologist, etc.

Section O:

- This section and the participant case summary should align. Be sure to update both at reassessment if guardianship changes.

Section S:

- Back-up plan should include the individual's name, phone number, and relationship to the participant.